PRINTED: 09/25/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 COM		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY  COMPLETED	
		09/10/2015				
	PROVIDER OR SUPPLIE		618 W	ADDRESS, CITY, STATE, ZIP CODE GLENBURN ROAD N, IN 47441		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
K 0000						
K 0000 Bldg. 01	A Life Safety C State Licensure the Indiana State accordance with Survey Date: 09 Facility Number Provider Number AIM Number: At this Life Safe Center At Glent substantial comp Requirements for Medicare/Medic 483.70(a), Life 9 2000 edition of Protection Asso Safety Code (LS Health Care Occ 16.2.  This one story for be of Type V (0) fully sprinklered alarm system with detectors in the	ode Recertification and Survey was conducted by the Department of Health in the 42 CFR 483.70(a).  19/10/15  17: 000230  18: 155524  100275000  19: 100275000  10: 10: 10: 10: 10: 10: 10: 10: 10: 10:	K 0000	By submitting the enclosed material we are not admitting to truth or accuracy of any specifindings or allegations. We reserve the right to contest the findings or allegations as part any proceedings and submitothese responses pursuant to or regulatory obligations. The fact request the plan of correction to considered our allegation of compliance effective September 28, 2015 to the state findings the Life Safety Code Recertification and State Licensure Survey conducted or September 10, 2015.	of our cility be er of	
	in the 400 north	hall, 500 north hall, 600 ll, and 700 rehabilitation				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	NSTRUCTION	(X3) DATE		
155524		B. W		01	COMPL 00/10		
		155524	D. W			09/10/	2015
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
	OFNITED AT OLEA	IDUDNILIONE			GLENBURN ROAD		
HEALTH	CENTER AT GLEN	IBURN HOME		LINTON	I, IN 47441		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	. •	s battery operated smoke					
		300 south hall, 400 south					
	hall, 500 south h	all and all Special Care					
	Unit resident sle	eping rooms, including					
	the 100 and 200	halls. The facility has a					
	capacity of 149 a	and had a census of 130					
	at the time of thi	s survey.					
		-					
	All areas where	residents have customary					
		nklered and all areas					
	providing facility						
		ept an attached structure					
	_	nance shop and storage					
	•	From the facility by a two					
	· ·	nd one detached garage					
	used for facility	storage.					
	Quality Review	completed 09/15/15 -					
	DA						
K 0018	NFPA 101						,
SS=B	LIFE SAFETY CO	DE STANDARD					
Bldg. 01		corridor openings in other					
	than required encl						
	' ' '	hazardous areas are such as those constructed					
		onded core wood, or					
		g fire for at least 20					
		sprinklered buildings are					
		sist the passage of					
		no impediment to the					
	•	rs. Doors are provided able for keeping the door					
		ors meeting 19.3.6.3.6 are					
	permitted. 19.3.	_					
		prohibited by CMS ealth care facilities.					

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Event ID:

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Facility ID: 000230

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>01</u> COMPLET			ETED		
		155524	B. WING 09/10/2015			2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	·	
NAME OF F	PROVIDER OR SUPPLIER				GLENBURN ROAD		
HEALTH	CENTER AT GLEN	IBURN HOME			N, IN 47441		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG			DATE
		ation and interview, the	K 0	018	The corrective action taken for th		09/29/2015
	facility failed to	ensure 1 of 1 sets of			residents found tobe affected by t deficient practice is that the slid		
	double doors to t	the corridor were			double doors identified duringthe		
	equipped with po	ositive latches and			survey on the linen closet of the		
	latched into the	door frame. This	1		Friendly Grove Unit have been		
	deficient practice	e could affect any			replacedwith framed positive late	hed	
	•	ents, as well as staff and	1		doors.		
		the Friendly Grove Hall					
		lls which pass through	1		The second of the contract of		
	this area.	ns which pass unough			The corrective action taken for the other residents having the potential		
	uns arca.				be affected by the same deficient		
	F: 1: : 1 1				practice is that a housewide audit		
	Findings include				been completed by themaintenant		
					director to determine if there are		
		ation on 09/10/15 at			other doors that do not meetthis		
	12:15 p.m. durin	g a tour of the facility			requirement. No other doors		
	with Maintenance	ee Supervisor, the set of			wereidentified.		
	double doors to t	the Friendly Grove Hall					
	clean linen close	t were sliding doors			The measures or systematic change	g o g	
	which did not lat	tch into the door frame.			that have been put intoplace to	ges	
	This was acknow	vledged by Maintenance			ensure that the deficient practice		
		e time of observation.	1		does not recur is that a mandatory	,	
	Super ribor at the	time of cool various.	1		in-service has been provided for		
	3 1 10(b)		1		themaintenance department staff		
	3.1-19(b)				the regulation related to acceptab		
			1		standardsrelated to doors protecti		
			1		corridor openings requiring positi	ive	
			1		door latches.		
			1				
					The corrective actionwill be		
			1		monitored to ensure the deficient		
					practice will not recur through		
			1		thequality assurance program by	a	
					Quality Assurance tool has been		
			1		developedand implemented to		
					monitor the type of doors that are		
					used to protect corridoropenings	to	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155524	A. BUILDING B. WING	<u>01</u>	COMPLETED 09/10/2015	
NAME OF PROVIDER OR SUPPLIER HEALTH CENTER AT GLENBURN HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 618 W GLENBURN ROAD LINTON, IN 47441				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
				ensure that they meet life safety of standards. This tool will be completed by theMaintenance Supervisor and/or his designee. Tool will be completed weekly for four weeks, then monthly for twomonths and then quarterly for three quarters. The outcomes will reviewed at the facility's Quarter QualityAssurance meeting to determine if any additional action warranted.	r'he r - I be Iy	

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	OF CORRECTION IDEN	PROVIDER/SUPPLIER/CLIA ITIFICATION NUMBER: 5524	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPLETED 09/10/2015	
NAME OF PROVIDER OR SUPPLIER HEALTH CENTER AT GLENBURN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 618 W GLENBURN ROAD LINTON, IN 47441			
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
K 0144 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE S Generators are inspect exercised under load formonth in accordance via 3.4.4.1.	ted weekly and or 30 minutes per				
	1. Based on record rethe facility failed to emergency generator		K 0144	1). The corrective action taken for those residents found to be affected by the deficient practice is that allresidents have the potential to be	d	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
i i		IDENTIFICATION NUMBER:	î í	A. BUILDING 01		COMPLETED	
155524		B. W	B. WING 09/10/201				
		<u> </u>		STREET /	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			GLENBURN ROAD		
	CENTER AT GLEN	NBURN HOME			N, IN 47441		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	affected. The facility is now	DATE	
		ordance with NFPA 99.			documenting weekly that each of	f the	
		.2 requires a written			facilities twogenerators are being		
	_	tion, performance,			inspected. The log also reflects the		
	exercising period	d and repairs shall be			each generator isexercised under		
	regularly mainta	ined and available for			load for 30 minutes each		
	inspection by the	e authority having			month. There is also documentat		
	jurisdiction. The	is deficient practice could			supporting that the cool down tir	nes	
	1 "	its, as well as staff and			arerecorded on the Emergency		
	visitors in the fa				Generator Manual Load Test Log	g.	
	Findings include:  Based on review of the facility's				2).The corrective action taken those residents foundto be	for	
					affected by the deficient pract is that allresidents have the		
		-			potential to be affected by this		
		erator monthly testing log			deficient practice. The facility now documenting that	'IS	
		0:45 a.m. with the			eachemergency generator that	at	
		pervisor present, the			provides power to the emerge		
	1 -	rm documented both			lighting system isexercised ur		
	generators were	tested monthly for 30			operating temperature condition		
	minutes under lo	oad, however, there was			at not less than 30 percent of		
	no documentation	on on the form that			EPS (Emergency Power Supplement of EPS) (EMERGENCY Power Supplemen		
	showed both ger	nerators had cool down			minimum of 30minutes.	a	
	I -	their load tests. During			midin or commutee.		
	1	he time of record review,					
		Supervisor confirmed			The corrective action taken fo	r	
		erator log did not include			the other residents havingthe		
		of the cool down times			potential to be affected by the		
		of the coor down times			same deficient practice is that facility has revised the log for		
	being recorded.				EmergencyGenerator Manual		
					Load Test. The log nowinclud		
	3.1-19(b)				that each of the facilities two		
					generators are being inspecte		
	2. Based on reco	ord review and interview,			weeklyand that each generate	or is	
	the facility failed	d to provide complete			exercised under load for 30		
	documentation f	For the testing of 1 of 2			minutes each month. There is also documentation included	8	
		rators providing power to			toreflect the cool down times		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			
155524		B. WING		09/10/2015	
AND PLAN	DENTIFICATION NUMBER: 155524  PROVIDER OR SUPPLIER  CENTER AT GLENBURN HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be	A. BUILDING B. WING  STREET ADDR 618 W GLE LINTON, IN  ID PREFIX TAG  following cor of t Sup mir mo  The cha into def is t ma ma the ger	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Illowing each generators onthly load test. The log also cludes documentation that chgenerator was exercised der operating temperature inditions or at not lessthan 3 the EPS (Emergency Power apply) nameplate rating for a nimum of 30 minutes each conth.  The measures or systematic anges that have been put oplace to ensure that the ficient practice does not receive that the facility has conducted and atory in-service for the aintenance department staff to changes to the emergency nerator logand their	(X5) COMPLETION DATE  O  0 % r  ur ed a  on	
	regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility.	the The mo	sponsibility in the completion to log weekly.  The corrective actionwill be conitored to ensure the deficient to the control of the control o		
	Findings include:  Based on review of the facility's Emergency Generator monthly testing log on 09/10/15 at 10:45 p.m. with the Maintenance Supervisor present, the	the Em Loa Qu forr bei wa	equality assurance program e submission of the complet nergencyGenerator Manual ad Test logs to the Quarter! uality Assurance meeting review. Additional action w implemented as deemed arranted by the Quality	ed y ill	
	generator log form documented the south generator was tested monthly under load, however, the documentation did not show the generator was exercised under operating temperature conditions or at not less than 30 percent of the EPS		surance Committee. This was an on-going process.	VIII	

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	of Correction identification number:  155524	A. BUILDING B. WING	ONSTRUCTION  01	COMPLETED 09/10/2015
	PROVIDER OR SUPPLIER  CENTER AT GLENBURN HOME	618 W	ADDRESS, CITY, STATE, ZIP CODE GLENBURN ROAD N, IN 47441	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	(Emergency Power Supply) nameplate rating for a minimum of 30 minutes during the past twelve months and was under the 30 percent requirement. The generator log form indicated the south generator was load tested at 28 % which did not meet the 30 percent requirement. This was acknowledged by the Maintenance Supervisor at the time of record review.  3.1-19(b)			

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		IDENTIFICATION NUMBER:  155524	A. BUILDING B. WING	01	COMPI 09/10	LETED	
NAME OF PROVIDER OR SUPPLIER  HEALTH CENTER AT GLENBURN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 618 W GLENBURN ROAD LINTON, IN 47441				
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE	

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	LETED /2015				
NAME OF PROVIDER OR SUPPLIER  HEALTH CENTER AT GLENBURN HOME  STREET ADDRESS, CITY, STATE, ZIP CODE  618 W GLENBURN ROAD  LINTON, IN 47441	STREET ADDRESS, CITY, STATE, ZIP CODE 618 W GLENBURN ROAD				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY	(X5) COMPLETION DATE				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155524		(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE COMPI <b>09/10</b>	LETED	
NAME OF PROVIDER OR SUPPLIER HEALTH CENTER AT GLENBURN HOME			618 W	ADDRESS, CITY, STATE, ZIP CODE GLENBURN ROAD N, IN 47441		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE

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